Benefit Enrollment Worksheet for the Period of 12/1/2015 through 11/30/2016

		Dollars paid by Employer per paycheck
Option A:	For Employees who elect a Medical Plan with ***Employee Only*** coverage	$75.84
Option B:	For Employees who elect a Medical Plan with ***Employee & Spouse*** coverage	$116.61
Option C:	For Employees who elect a Medical Plan with ***Employee & Child(ren)*** coverage	$115.34
Option D:	For Employees who elect a Medical Plan with ***Family*** coverage	$163.87

Medical Plans — **Total Cost per Paycheck**

	Plan Choices	Waiver	A	B	C	D	
Plan 1	$1000 Deductible		$147.94	$295.89	$266.30	$443.83	
Plan 2	$2000 Deductible		$130.92	$261.83	$235.65	$392.75	
Plan 3	$5000 Deductible		$119.62	$253.42	$228.08	$380.13	
Plan 4	$3500 HSA		$91.36	$182.72	$164.45	$274.08	

Dental Plan

	Waiver	A	B	C	D	
Delta Dental		7.67	15.12	15.65	27.09	

Vision Plan

	Waiver	A	B	C	D	
VIPA		1.71	3.42	3.42	4.52	

Accidental Death & Dismemberment		**No Cost**
Life Insurance Policy	1 times Salary	**No Cost**

Line A: Add all Premiums above: _____

Line B: List Employer Contribution: _____

Line C: Subtract Line B from Line A
Employee Total Cost Per Paycheck _____

Employee Name (Print): _____

Employee Signature: _____

Date: _____ Social Security Number: _____

I understand that the choices I have indicated on the worksheet must remain in effect for the entire plan year unless I have a change in family status.

A change in family status includes the birth of adoption of a child, marriage, divorce, death, spouse losing/gaining a job or employement status from part-time to full-time or full-time to part-time.

I hereby give my employer permission to reduce my salary by the above-elected amounts.
I understand that premiums I am obligated to pay for will be deducted from my pay on a before-tax basis.